

# MEDICAID

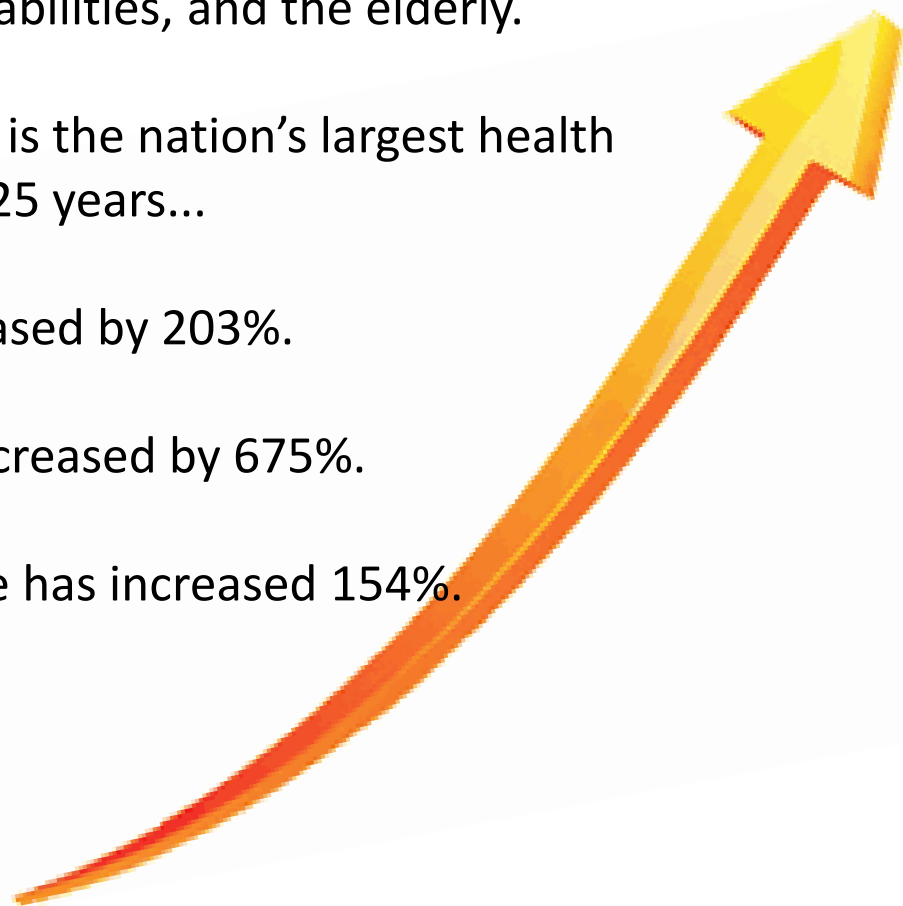
An Introduction to America's Largest Health Program

## 1965 TO TODAY

In 1965, Medicaid was created as a joint federal-state program to provide health coverage to certain categories of low-income people: children, pregnant women, people with disabilities, and the elderly.

Today, 50 years later, the program is the nation's largest health coverage program. Over the past 25 years...

- Medicaid enrollment has increased by 203%.
- Medicaid expenditures have increased by 675%.
- Medicaid spending per enrollee has increased 154%.



# HISTORY OF MEDICAID'S EVOLUTION

**1965:** Medicaid enacted as Title XIX of the Social Security Act.

**1967:** The Social Security Amendments of 1967 mandated Early and Periodic Screening, Diagnostic, and Treatment services for eligible children up to age 21.

**1972:** States permitted to link Supplemental Security Income and Medicaid eligibility.

**1977:** Hyde Amendment prohibited federal payments for abortions in most cases.

**1981:** States are allowed to make payments to disproportionate share hospitals. Section 1915(b) and 1915(c) waivers were created to allow managed care enrollment and home- and community-based long-term care services.

**1982:** All states have joined Medicaid.

**1986:** States required to cover emergency medical conditions for illegal aliens and given option to cover pregnant women and children <100% FPL.

**1987:** States given option to cover pregnant women and children <185% FPL.

**1989:** Coverage required for pregnant women and children under 6 <133% FPL.

## HISTORY OF MEDICAID'S EVOLUTION (2)

**1990:** Coverage required for children aged 6-18 in families <100% FPL and the Medicaid prescription drug rebate program is established.

**1991:** Ceiling placed on special payments to DSH hospitals.

**1996:** Welfare reform legislation broke formal link between welfare and Medicaid eligibility.

**1997:** The State Children's Health Insurance Program was created. States are allowed to require managed care for certain beneficiaries without a 1915(b) waiver.

**1999:** States are allowed to cover working disabled >250% FPL.

**2003:** Drug coverage for individuals eligible for Medicare and Medicaid (dual eligibles) shifted from Medicaid to Medicare with the creation of the Medicare Part D prescription drug program.

**2010:** PPACA allows states to expand their Medicaid programs beginning in 2014 to cover any childless adult below 138% FPL. The federal government pays for 100% of the cost of this expansion for the first 2 years but eventually scales back to 90% in 2020 and thereafter.

# WHAT IS MEDICAID?

- Federal-state health care program created by the Social Security Amendments of 1965 under Title XIX of the Social Security Act.
- Today covers more than 71.8 million Americans (2015).
- Means-tested eligibility (determined by income).
- An entitlement program (benefits are guaranteed and enrollment freezes are not allowed).
- Participation is not mandatory, though all 50 states and territories participate.
- Funded by the federal and state governments.
- Covers medical benefits and long-term services and supports.



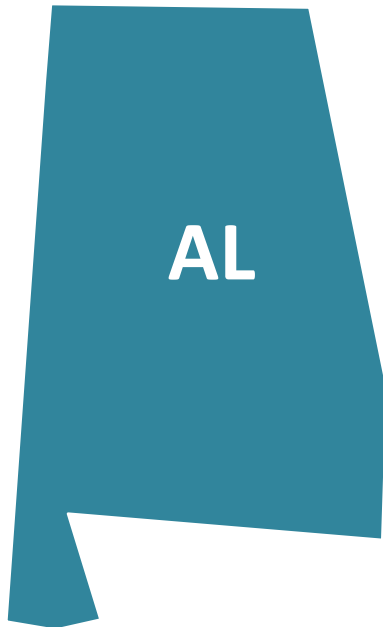
# MEDICAID ELIGIBILITY

Medicaid eligibility is determined by eligibility category and income level. There are minimum federal standards for coverage. The federal minimum for coverage ranges from 133% federal poverty level (FPL) for pregnant women to 28% FPL for working parents.



# INCOME ELIGIBILITY VARIES BY STATE

State eligibility thresholds can go above federal minimums, so there is significant variation in income thresholds for Medicaid eligibility.



For example: DC covers parents of dependent children up to 221% FPL while Alabama covers up to 18% FPL.



# WHO IS ELIGIBLE? CITIZENS AND LEGAL RESIDENTS

The Deficit Reduction Act of 2005 requires Medicaid applicants to provide evidence of citizenship or legal permanent status for permanent coverage. However, currently, States are required to provide coverage for applicants during a “reasonable opportunity period” if they are otherwise eligible but have not provided the required documentation of legal status.





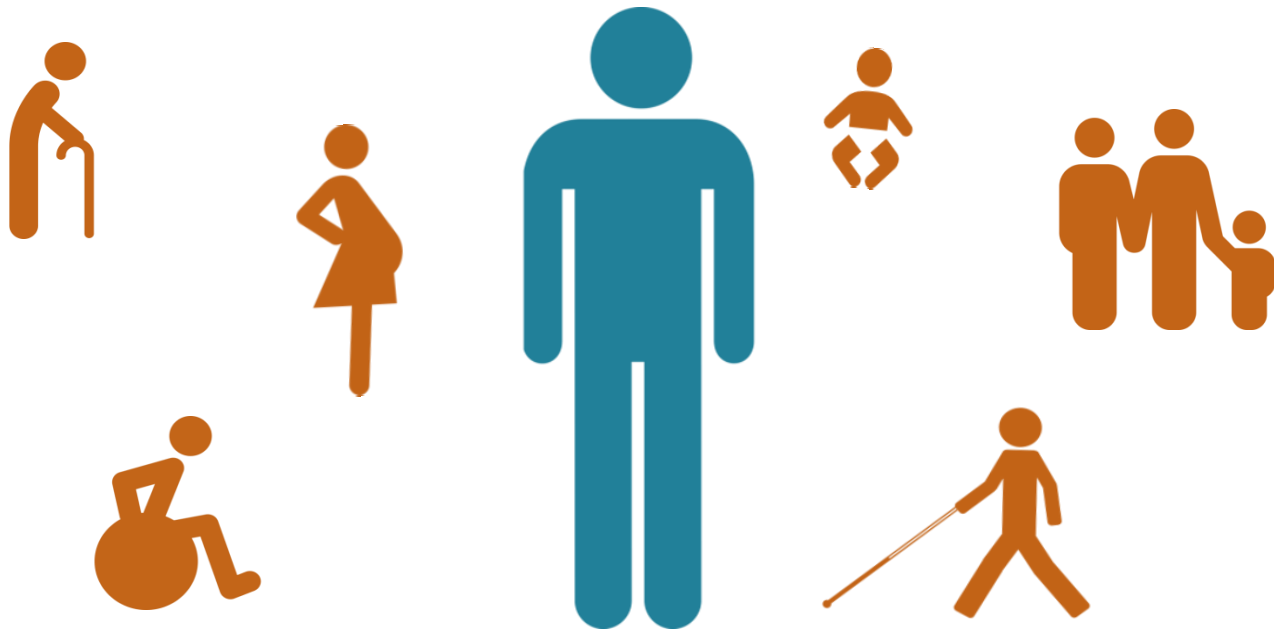
# DUAL ELIGIBLES COVERED IN MEDICARE AND MEDICAID



A person who qualifies for both Medicaid and Medicare (Part A and/or Part B) is considered to be a “dual-eligible beneficiary.” Medicare first pays for any eligible services and then Medicaid is used to cover additional care. There were 9.97 million dual eligibles in FY2011.

# THE ACA EXTENDS ELIGIBILITY TO ABLE-BODIED ADULTS

The Patient Protection and Affordable Care Act allows states to expand Medicaid eligibility to millions of able-bodied adults without dependent children who previously did not qualify for the program. In states that choose to expand their Medicaid programs, adults making up to 138% of the FPL are eligible to receive Medicaid benefits, paid for by the federal government through 2016, after which the federal government picks up no less than 90% of the costs in perpetuity under current law.



# MANDATORY BENEFITS

- Inpatient hospital services
- Outpatient hospital services
- Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT), including dental services for children
- Nursing facility services
- Home health services
- Physician services
- Laboratory and X-ray services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Transportation to medical care
- Tobacco cessation counseling for pregnant women
- Family planning services



# OPTIONAL BENEFITS

- Prescription drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing, and language disorder services
- Respiratory care services
- Podiatry services
- Optometry services
- Dental services for adults
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Private duty nursing services
- Hospice
- Case management
- Services for individuals 65 or older in an institution for mental disease
- Services in an intermediate care facility for the mentally retarded
- Tuberculosis related services
- Inpatient psychiatric services for individuals under age 21



# MEDICAID FINANCES NEARLY HALF OF ALL BIRTHS

In 2010, Medicaid financed 45 percent of births nationwide and at least 50 percent of the births in 16 states.



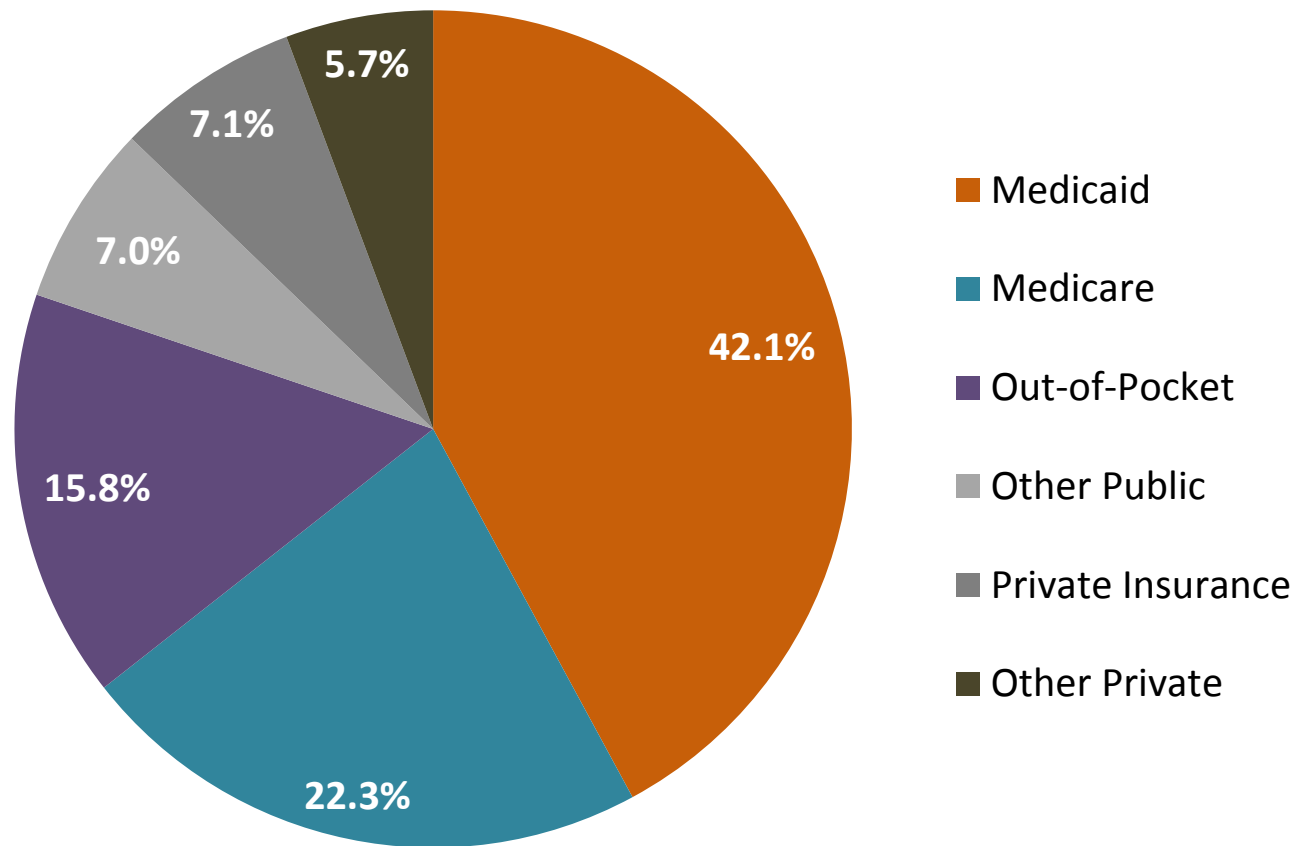
## LONG-TERM SERVICES AND SUPPORTS

- Long-term services and supports (LTSS) is a benefit that provides a range of services to help beneficiaries meet their personal care needs.
- LTSS generally includes assistance with activities of daily living such as bathing, dressing, using the bathroom, or eating and instrumental activities of daily living such as housework, money management, taking medication, shopping, using the phone, and caring for pets.
- LTSS is generally provided through home care services, community support services, participant directed serviced, facility-based services, and facility-based programs.



# PRIMARY PAYER OF LONG TERM SERVICES & SUPPORTS

In 2014, an estimated \$337.3 billion was spent on LTSS, representing 13.2% of personal health expenditures. Medicaid was the largest payer, spending \$142.1 billion.



# BENEFICIARY COST-SHARING

States have limited flexibility to charge nominal premiums and to establish out of pocket (copayments, coinsurance, deductibles, etc.) spending requirements, subject to a number of restrictions.

Maximum out-of-pocket costs are determined by income level, certain services (emergency, family planning, etc.) must be provided free of charge, and certain groups are exempt.





# MEDICAID DELIVERY SYSTEMS

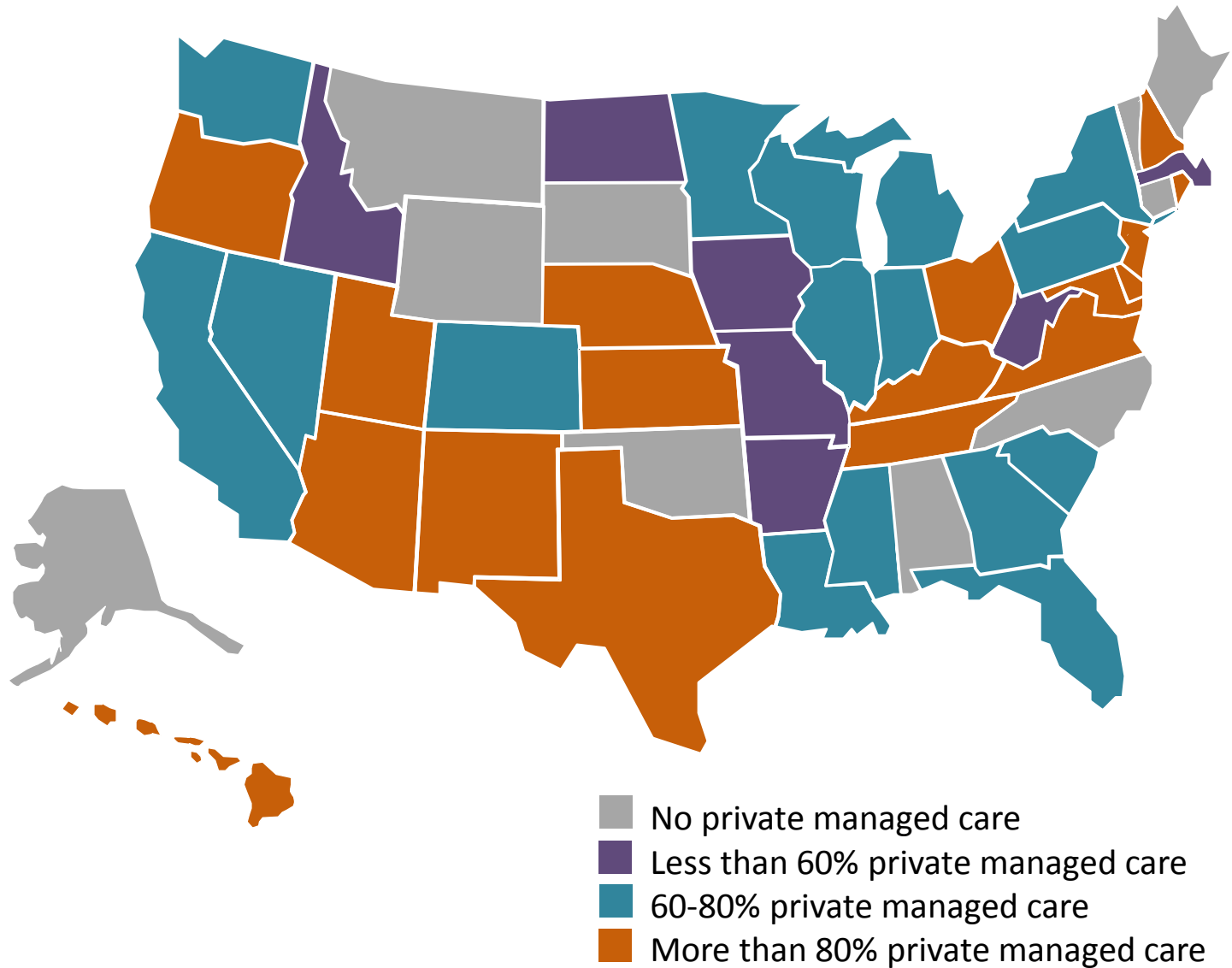
There are three primary Medicaid delivery models which states use.

- **Fee For Service (FFS).** In the FFS model, the state reimburses providers for each service provided to enrollees.
- **Managed Care Organizations (MCOs).** States contract with MCOs to provide a set package of benefits to certain enrollees. States pay the MCO a fixed monthly rate per enrollee to arrange for most health services.
- **Primary Care Case Management (PCCM).** States contract with primary care providers to provide case management services to enrollees. Under PCCM arrangements, the primary care providers receive a monthly case management per enrollee in addition to fee for service payments for the medical services utilized by the enrollees.

About two thirds of Medicaid beneficiaries are enrolled in PCCM or MCOs.



# MEDICAID MANAGED CARE ENROLLMENT, 2015



# MEDICAID WAIVERS

States can seek waivers to certain federal Medicaid requirements from CMS. The three primary types of waivers are defined in federal statute.

**Section 1115: Research & Demonstration Projects.** Program flexibility to test new or existing approaches to financing and delivering Medicaid. In fiscal year 2014, section 1115 demonstrations accounted for close to one third of total Medicaid expenditures.

**Section 1915(b): Managed Care Waivers.** Provide services through managed care delivery systems or otherwise limit people's choice of providers.

**Section 1915(c): Home and Community-Based Services Waivers.** Provide long-term care services in home and community settings rather than institutional settings.



# BUDGET NEUTRALITY FOR WAIVERS

HHS policy requires Section 1115 waivers to be “budget neutral,” meaning that spending under the waiver is not supposed to cost the federal government more than it would without the waiver. However, GAO has found that CMS does not always enforce this policy and some approved waivers have increased costs to the federal government.



# FEDERAL GOV'T MATCHES STATE EXPENDITURES

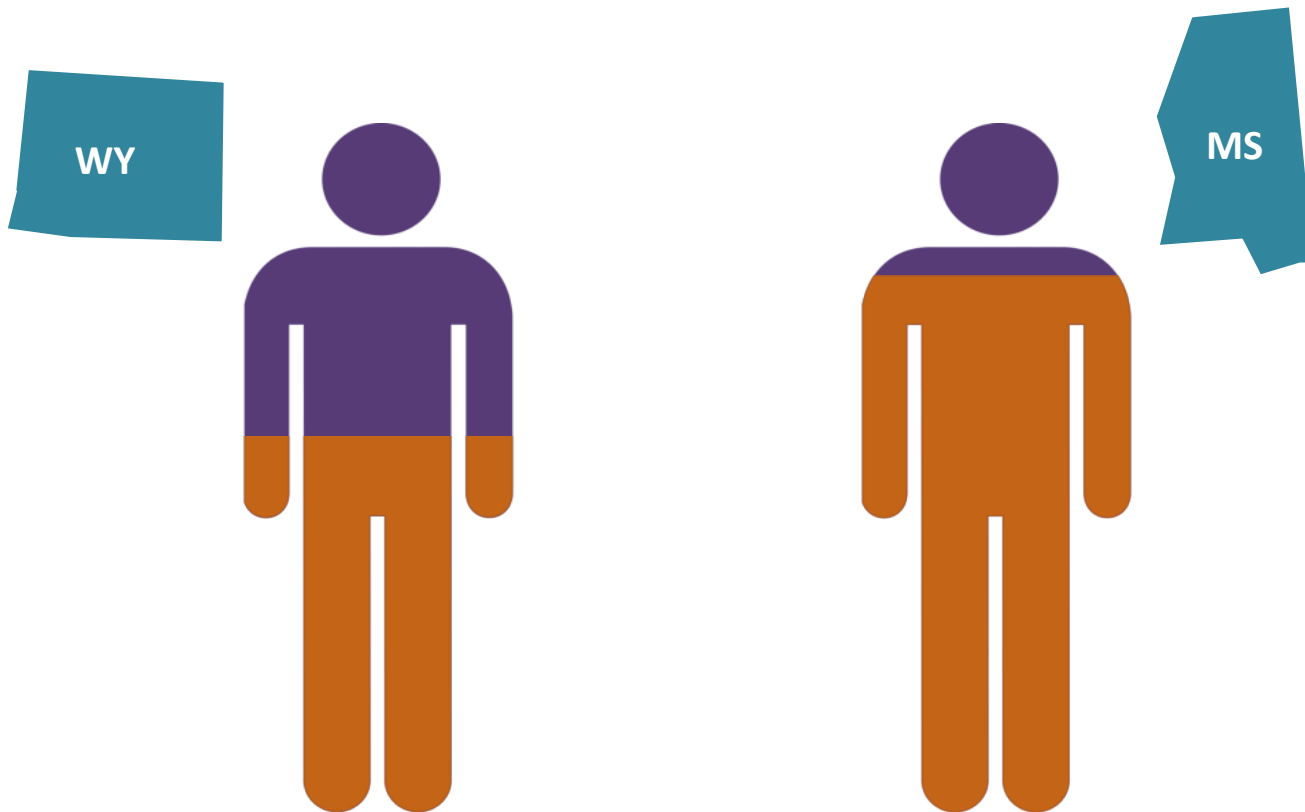


The federal medical assistance percentage (FMAP) rate determines the federal government's share of Medicaid payments. FMAP is established annually and varies by state. For most populations the FMAP is determined according to each state's per capita income relative to the national per capita income.

In fiscal year 2013, the federal government accounted for 58%, \$263.1 billion, of all Medicaid expenditures, while state government covered the other 42%, or \$193.0 billion. In future fiscal years, the CMS actuary projects that the federal government will pay 60% of Medicaid expenditures.

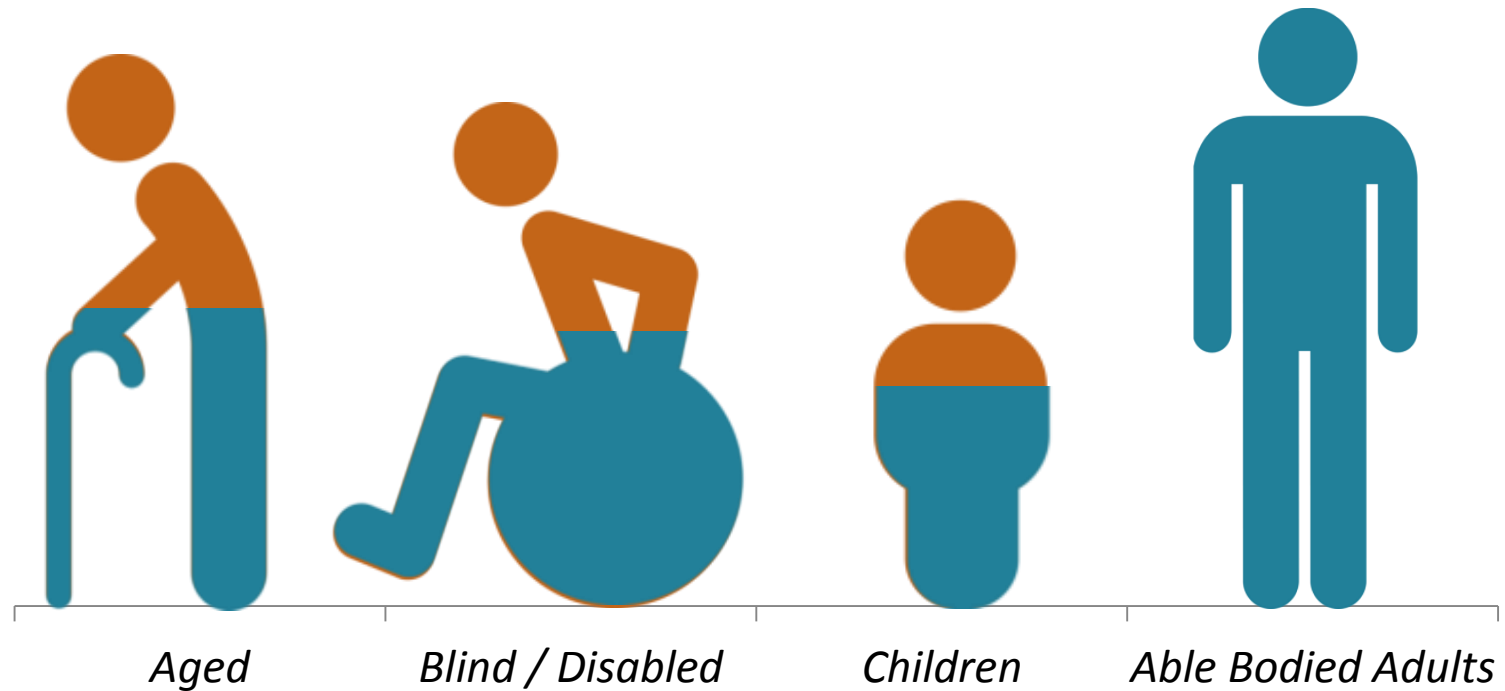
## FMAP VARIES AROUND THE NATION

Federal rules set the minimum FMAP rate for most expenditures at 50% and the maximum at 83%. For FY2016, 13 states will have the minimum FMAP while Mississippi had the highest FMAP at 74.17%.



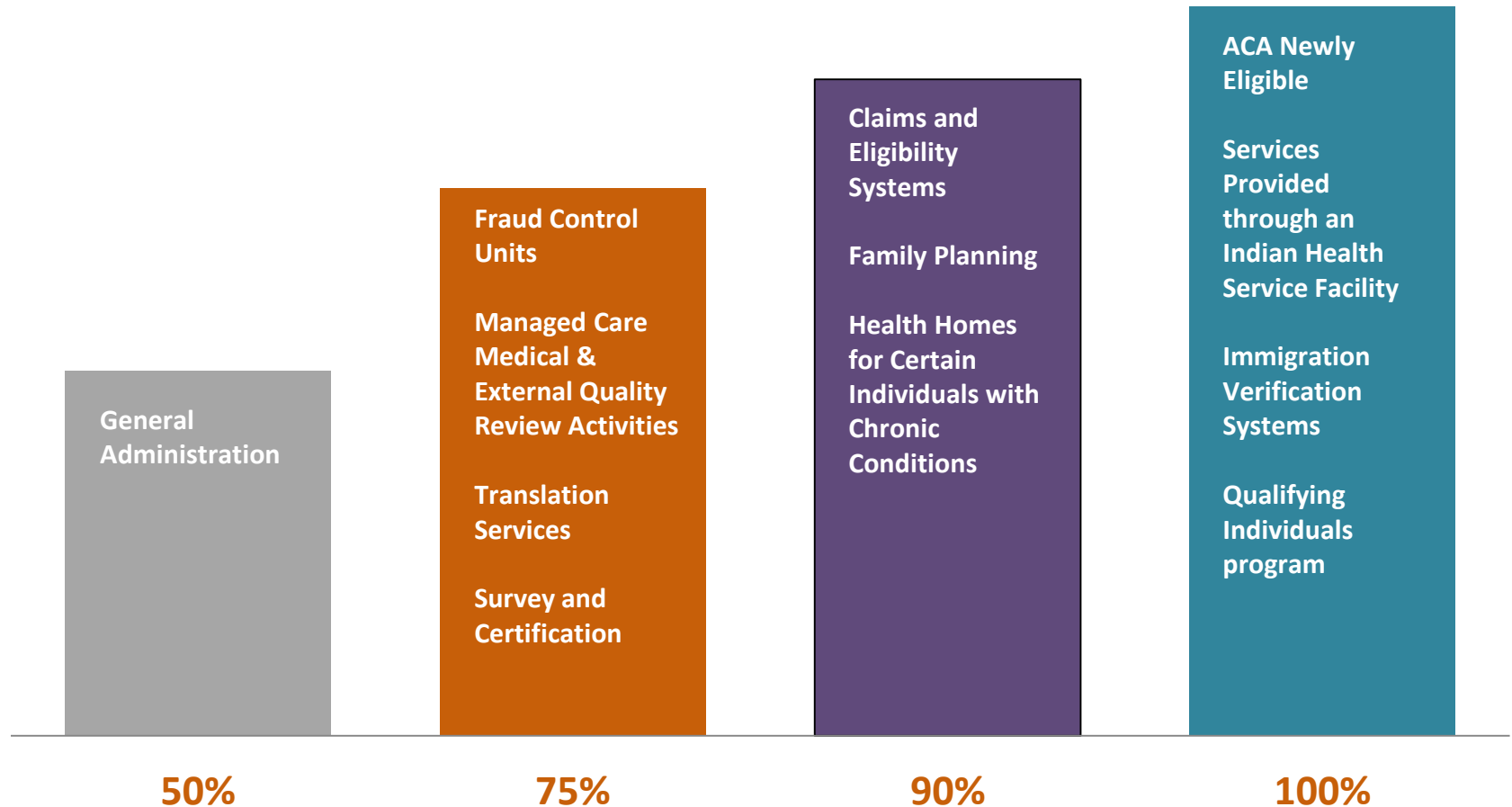
## EXPANSION POPULATION RECEIVES ENHANCED MATCH

The Patient Protection and Affordable Care Act specified the FMAP for the newly-eligible population at 100% through CY 2016. Meanwhile, the traditional Medicaid populations have a 57% FMAP *on average*.



# Exceptions to the FMAP

Numerous exceptions exist to the standard FMAP rate. For example, the FMAP rate is set at 55% for territories and 70% for the District of Columbia. There are also exceptions for certain populations, providers, and services.

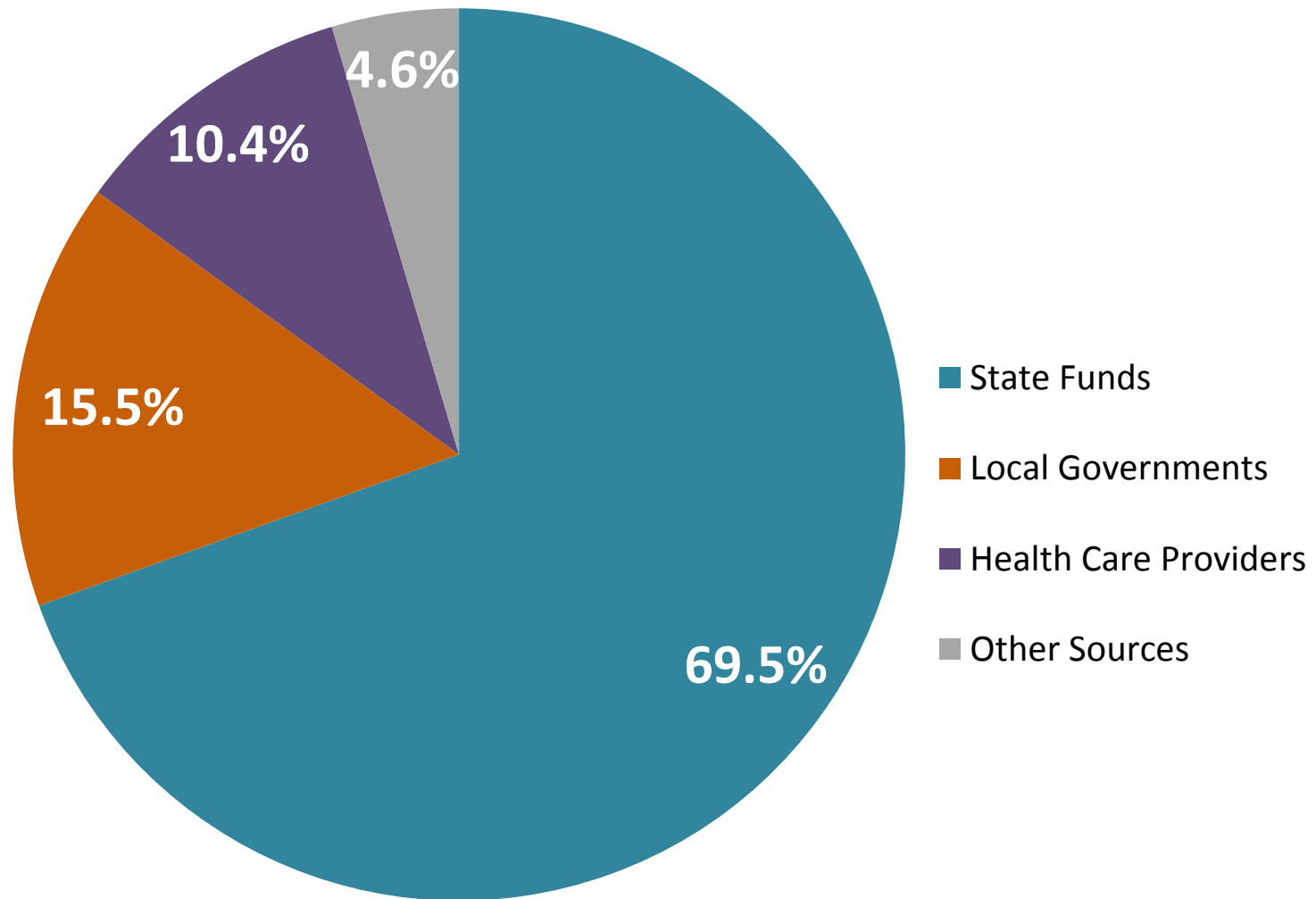




# MEDICAID CONSUMED MORE THAN ONE QUARTER OF STATE BUDGETS (FY2015)

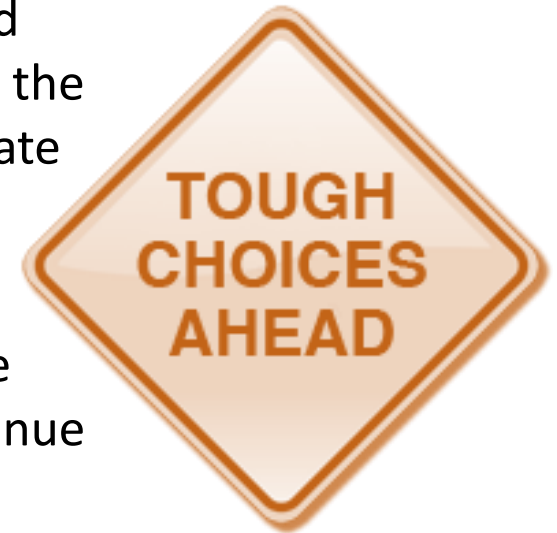


# SOURCE OF NON-FEDERAL SHARE OF MEDICAID FUNDS

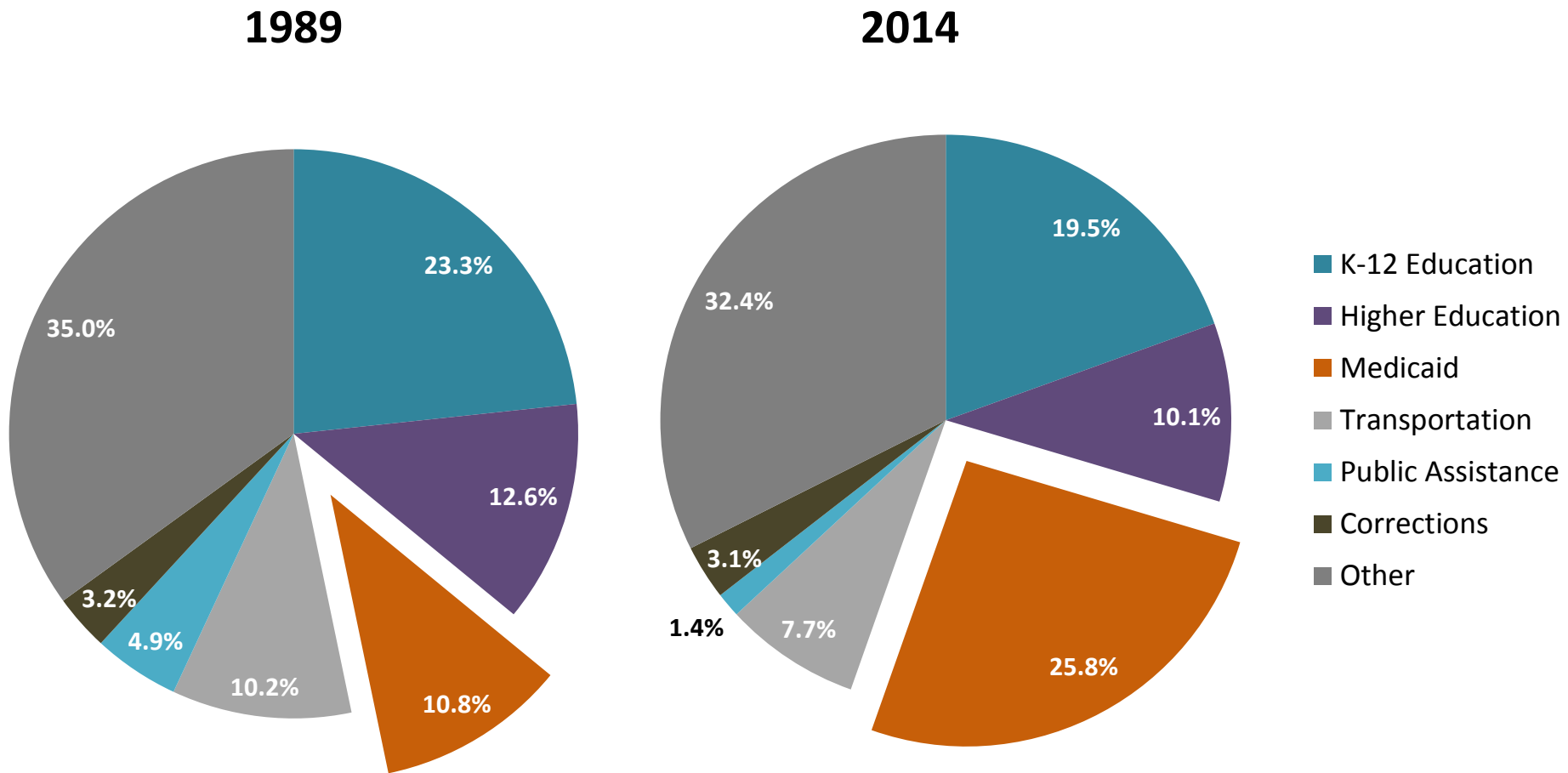


# MEDICAID PUTS PRESSURE ON STATE BUDGETS

- “A primary driver of the decline in the [state and local government] sector’s operating balance in the long term is the rising health-related costs of state and local expenditures on Medicaid...”
- Absent any intervention or policy changes, state and local governments are facing, and will continue to face, an increasing gap between receipts and expenditures in the coming years...
- We calculated that closing the fiscal gap would require action to be taken today and maintained for each year equivalent to an 18 percent reduction in the state and local government sector’s current expenditures.”



# MEDICAID HAS CROWDED OUT OTHER STATE PRIORITIES



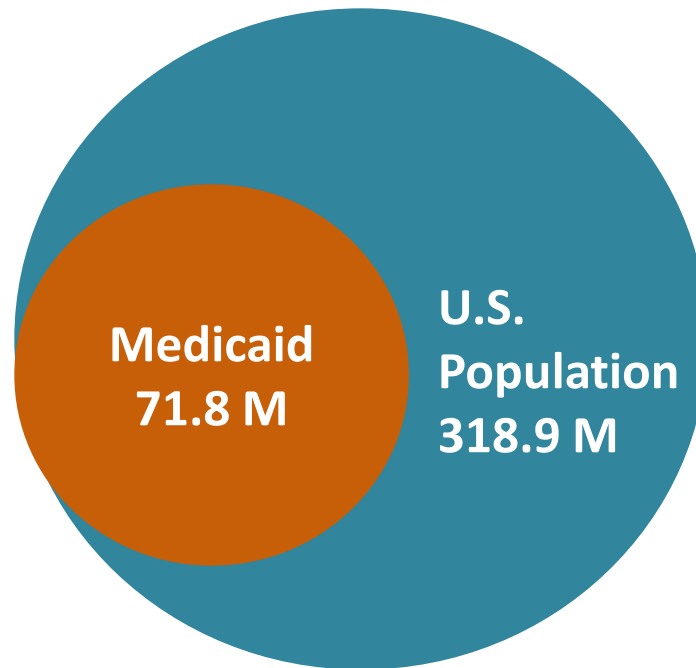
# STATE FINANCING SCHEMES INCREASE FEDERAL COSTS

States use a number of financial arrangements to secure more federal money for their Medicaid programs. For example, many states tax health care providers to generate revenue. This revenue in turn is spent by the state in its Medicaid program and matched by the federal government – which draws down more federal dollars. Then the state reimburses the provider for the cost of the tax and spends the increased matching funds on general state programs.

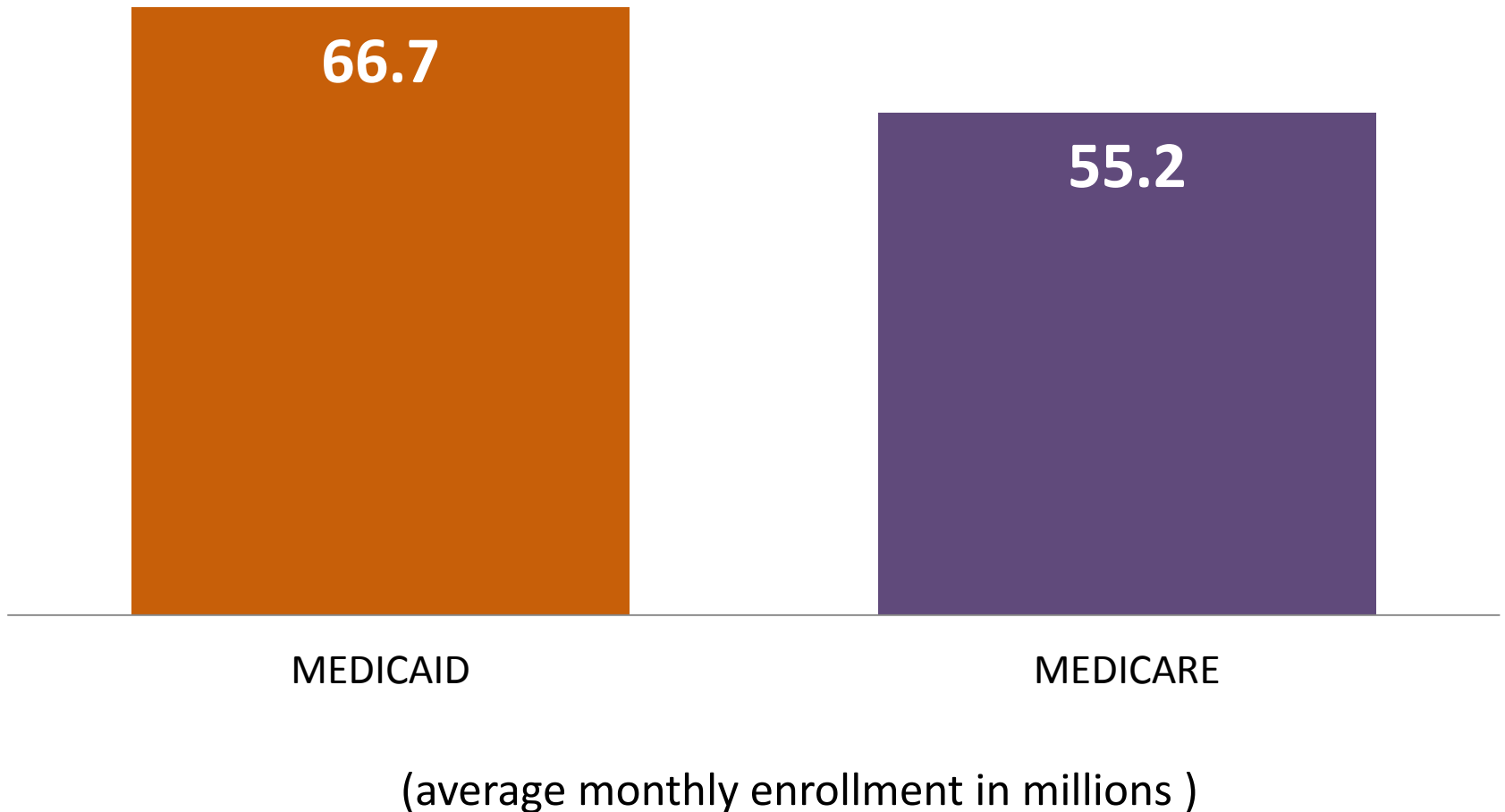


# 71.8 MILLION

The number of Americans enrolled in Medicaid in October 2015

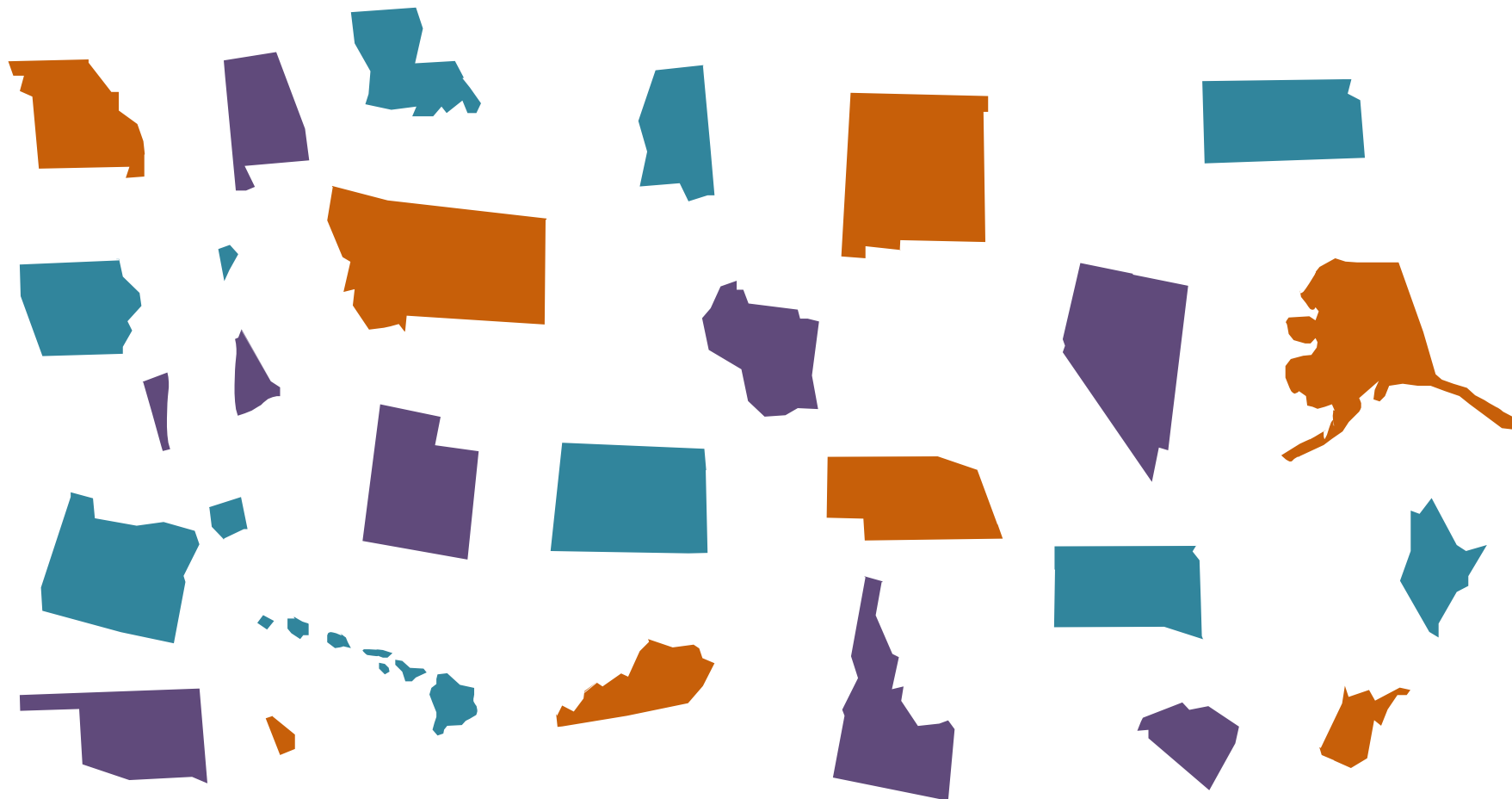


# LARGEST PUBLIC HEALTH INSURANCE PROGRAM (FY2015)



# ENROLLMENT LARGER THAN MANY STATES COMBINED

71.8 million people on Medicaid. This total is more than the population of the 29 least populous states combined.






## ENROLLMENT EXCEEDS POPULATION MOST COUNTRIES

If the Medicaid population in the United States were its own country, it would be the 21st most populous country in the world—larger than France, or Italy, or Spain, or the United Kingdom.

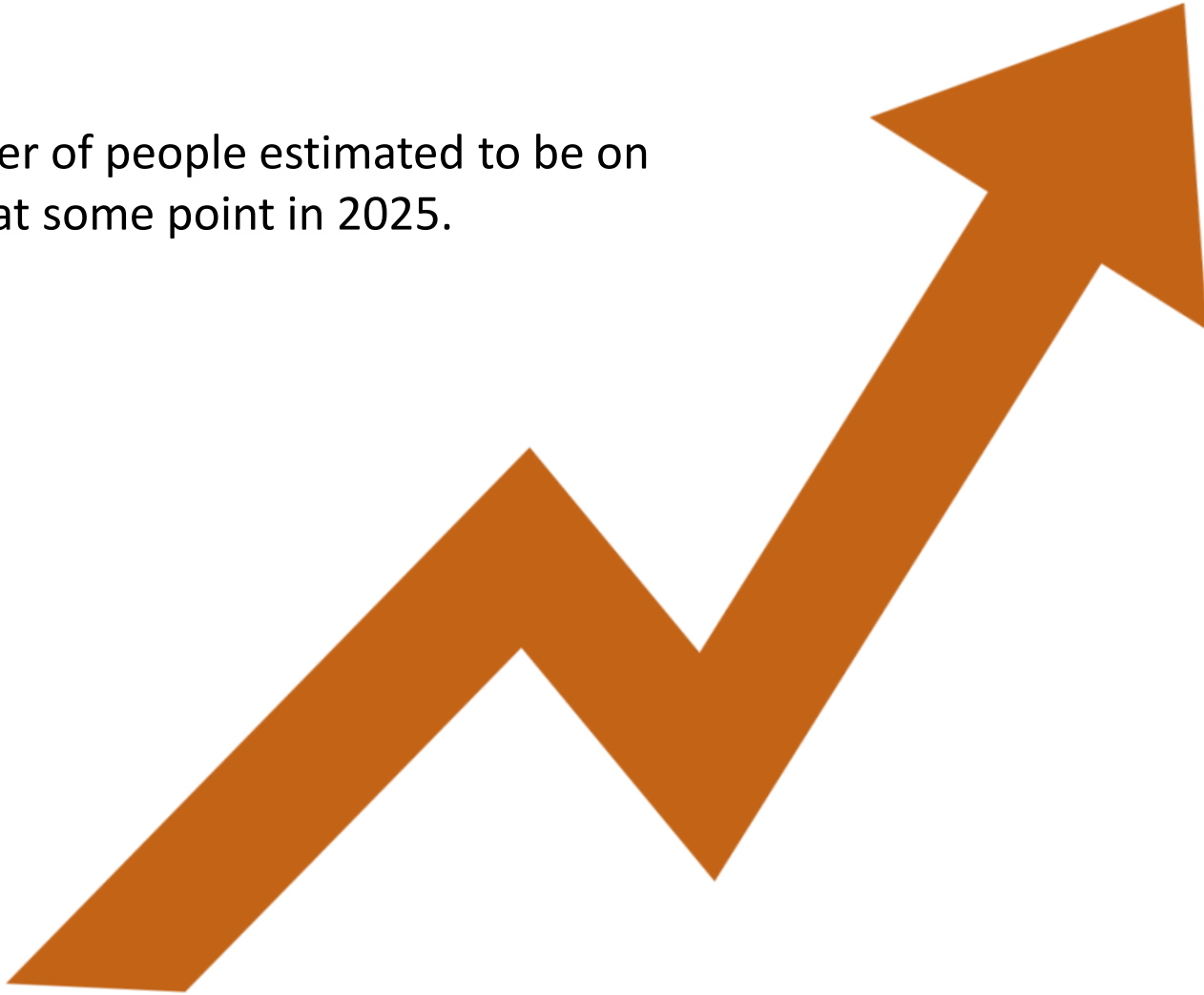




In **2014**, nearly 1 in 4  
Americans were enrolled in  
Medicaid at some point during  
the year

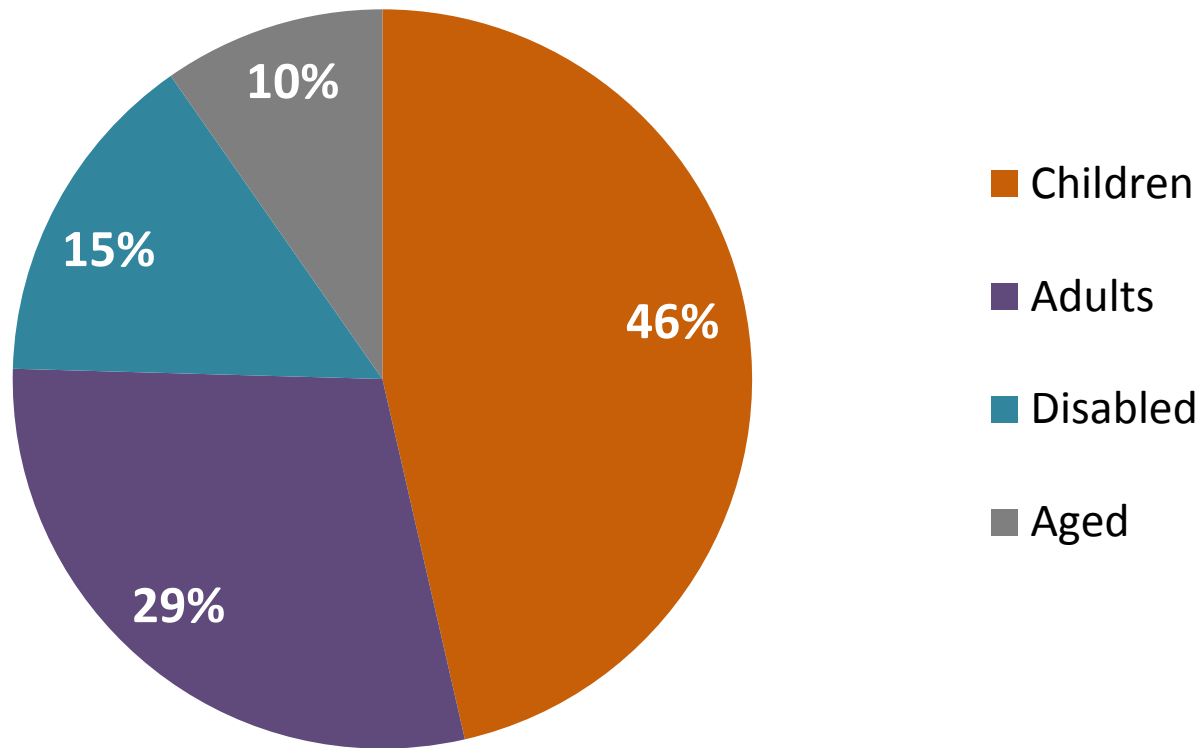
# 98 MILLION IN 2025

The number of people estimated to be on Medicaid at some point in 2025.



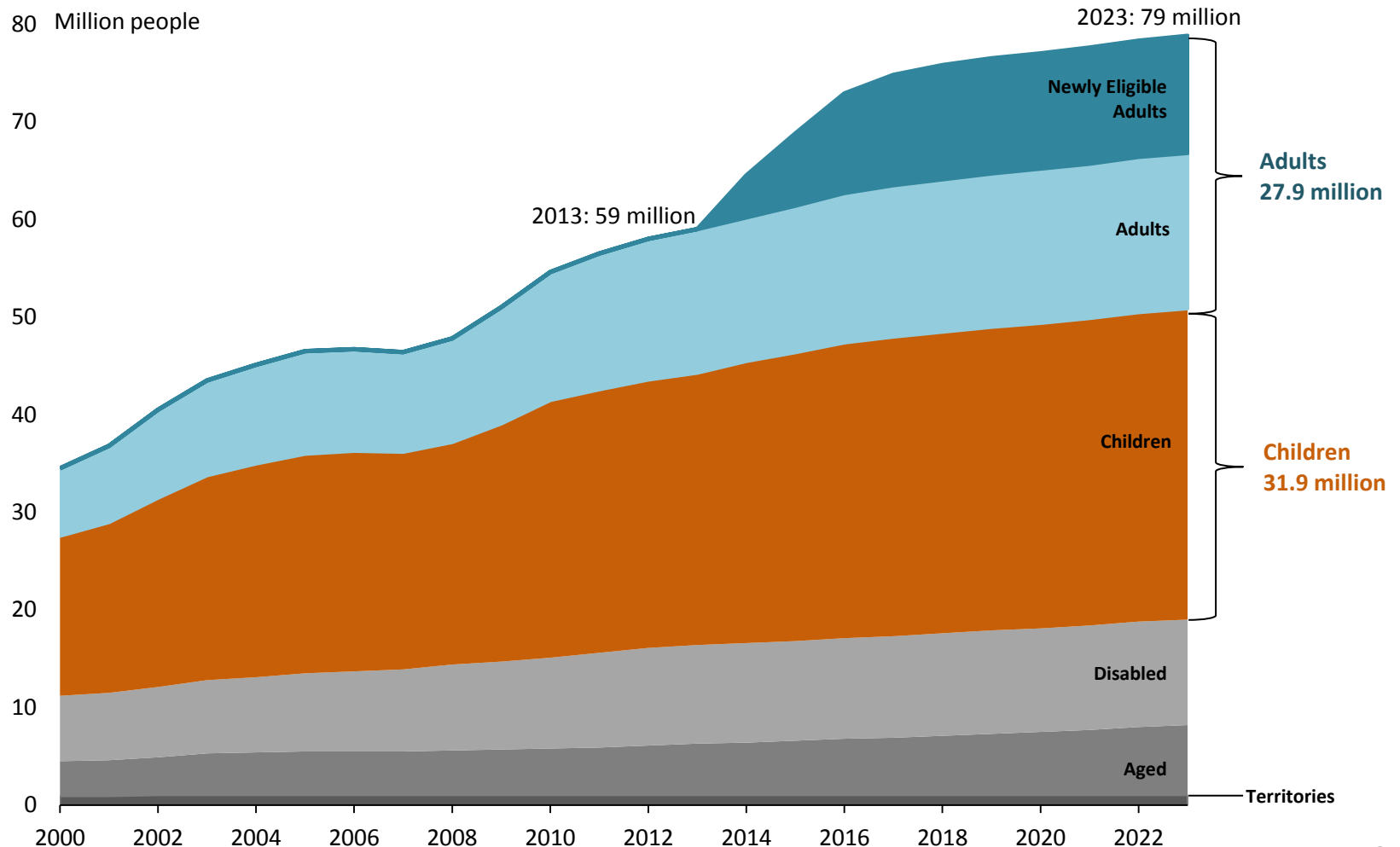
## ENROLLMENT BY ELIGIBILITY GROUP

Of the nearly 69 million people enrolled in Medicaid in FY 2012, children represented nearly half of all beneficiaries, followed by adults, disabled, and aged.

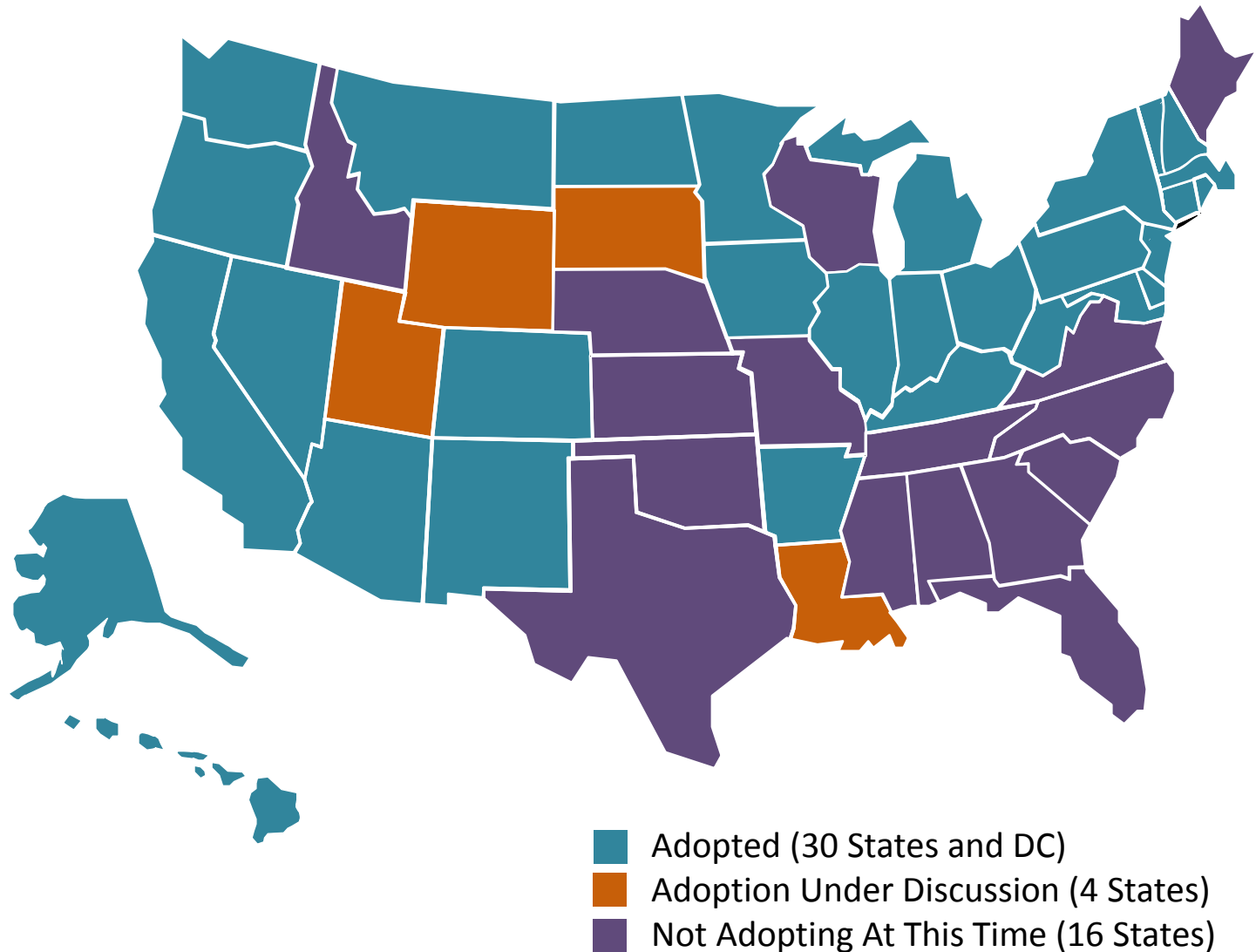


# CHANGING ENROLLMENT IN MEDICAID

Medicaid was historically a program for children, the aged, and disabled. However, under ACA, the CMS Office of the Actuary projects that, by 2023, there will be nearly as many non-disabled adults in Medicaid as children.



# STATE MEDICAID EXPANSION DECISIONS



# 12,000,000

CBO estimates that the Patient Protection and Affordable Care Act will increase enrollment in Medicaid and CHIP by 12 million enrollees by 2018.



# 1 IN 4 NEW ACA ENROLLEES WERE ALREADY ELIGIBLE

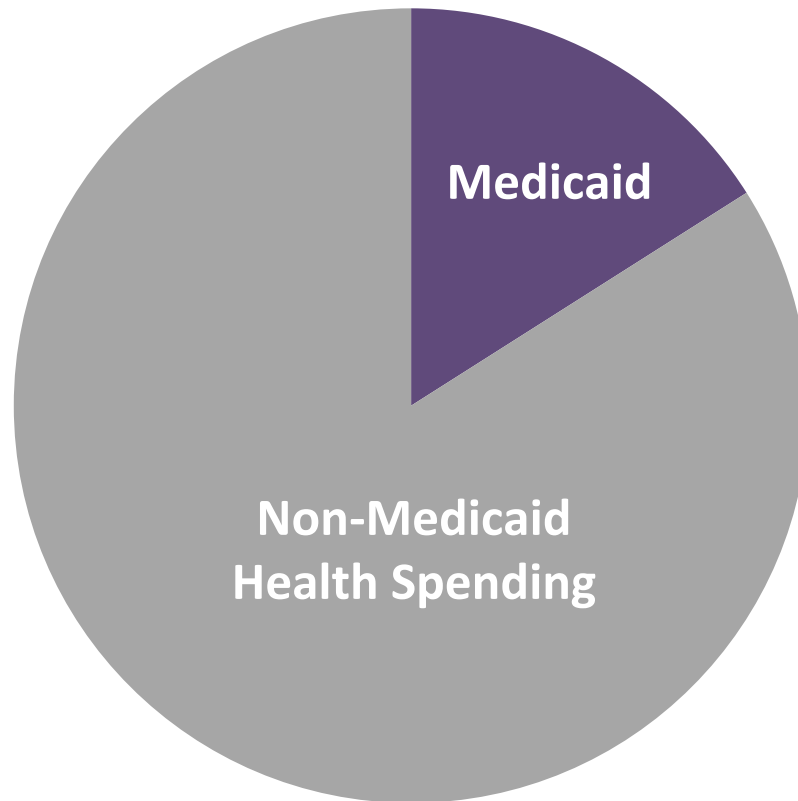
The “woodwork” effect describes the phenomenon of people who were already eligible for Medicaid prior to expansion enrolling. This newly-enrolled, but not newly-eligible population creates problems in non-expansion states that are not receiving additional federal funding for their Medicaid programs. CMS Office of the Actuary notes that about one in four of those who newly-enrolled in Medicaid in 2014 were eligible the prior year before expansion.



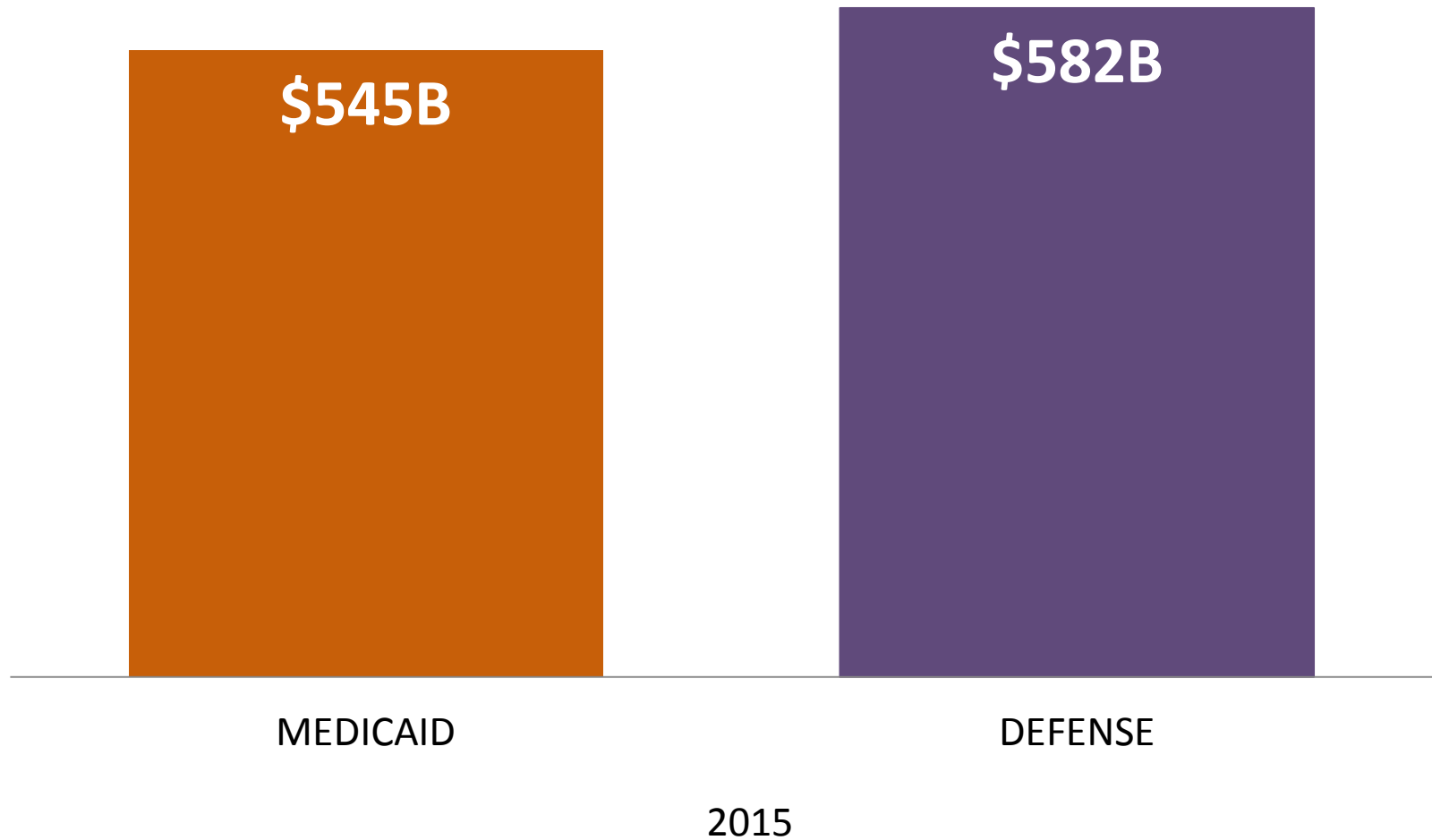


# \$496 BILLION

Total federal and state spending on Medicaid in 2014 was \$496 B, or 16% of national health expenditures.



# TOTAL MEDICAID SPENDING WILL SOON OVERTAKE FEDERAL DEFENSE SPENDING





**\$8,977**

**The per household cost of the  
Medicaid program for every  
household that paid federal  
income tax in 2013**

# \$7,482

The average cost of each Medicaid enrollee across all states and eligibility groups in FY 2012.

## PER ENROLLEE SPENDING VARIES ACROSS STATES



Average annual spending per child ranged from \$1,797 to \$6,085 and averaged \$2,696 per enrollee.



Average annual spending per adult ranged from \$2,619 to \$8,746 and averaged \$4,960 per enrollee.

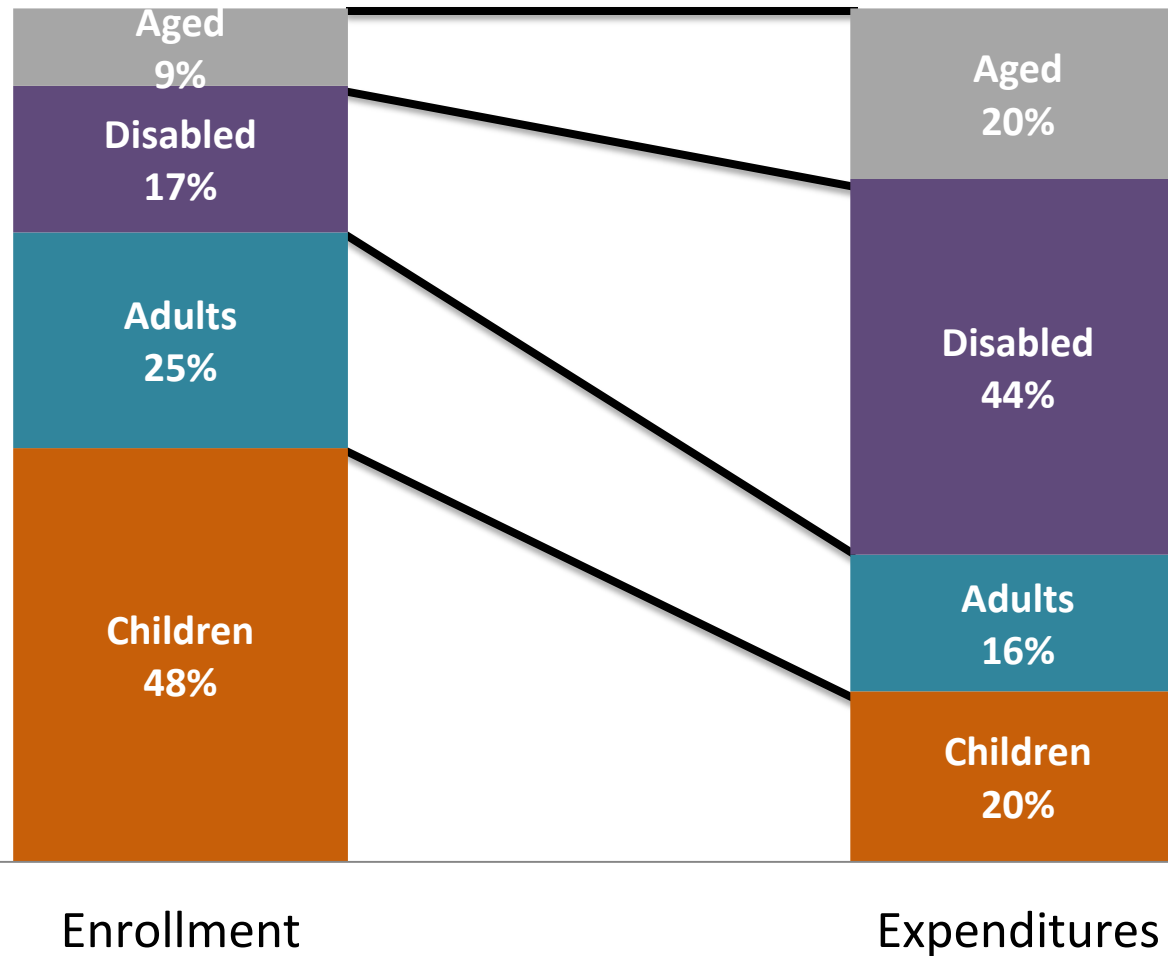


Average annual spending per aged enrollee ranged from \$3,586 to \$41,818 and averaged \$19,563 per enrollee.



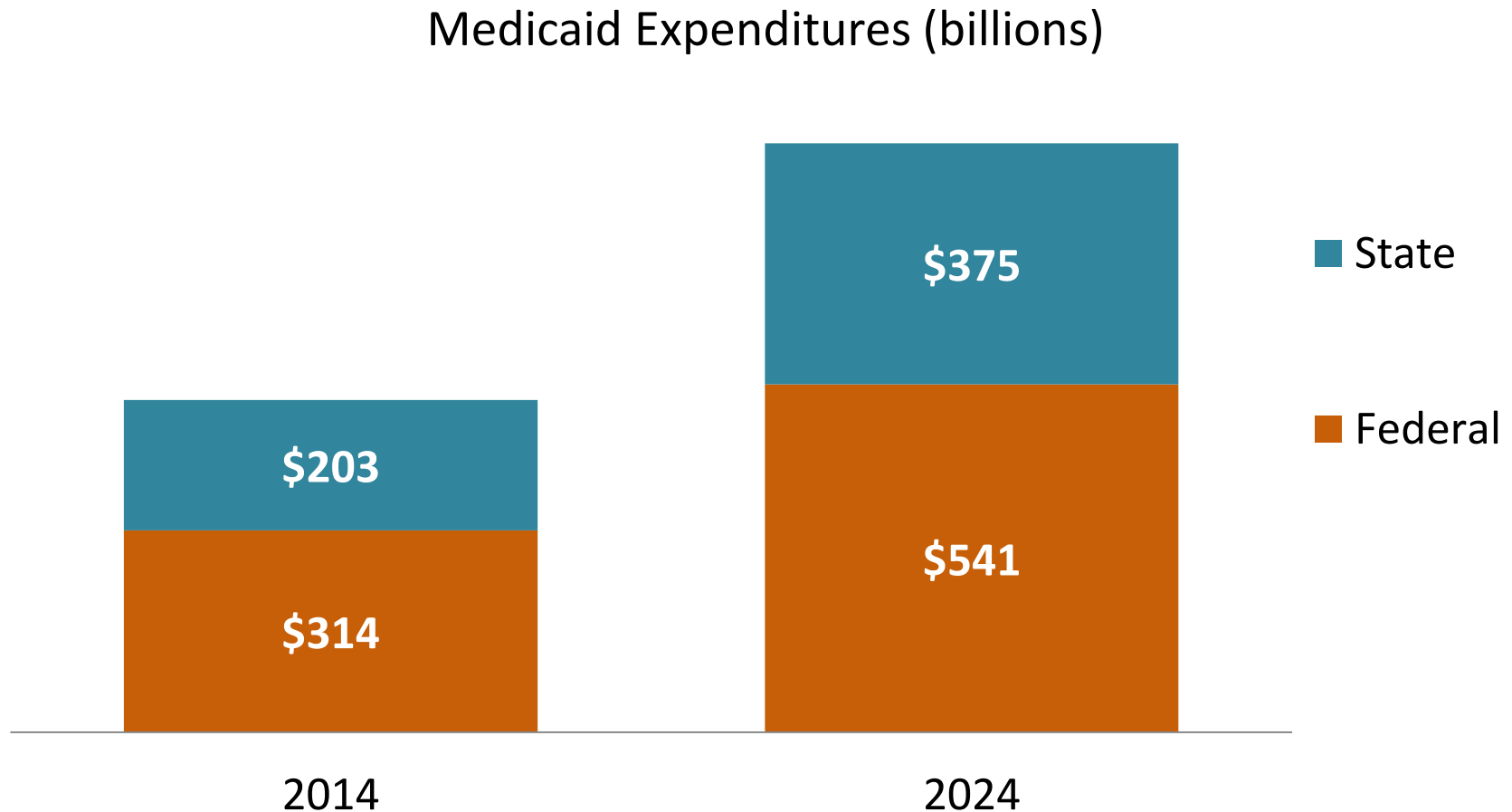
Average annual spending per disabled enrollee ranged from \$11,032 to \$36,752 and averaged \$19,660 per enrollee.

# MEDICAID SPENDING BY ENROLLMENT TYPE (FY2013)



# TOTAL SPENDING TO DOUBLE IN 10 YEAR PERIOD

Government projections suggest that total Medicaid spending will rise 6.4 percent per year, on average, after ACA's expansion.



# A HIGH RISK PROGRAM WITH HIGH ERROR RATES



The Government Accountability Office designates Medicaid as a high risk program.

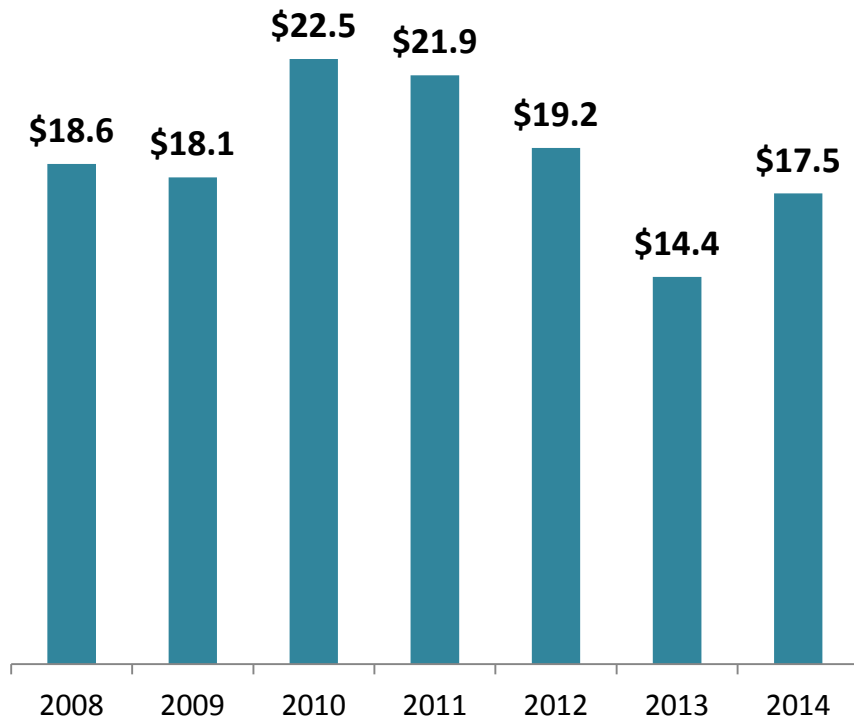
The Office of Management and Budget lists Medicaid as a high error program.



# MEDICAID'S IMPROPER PAYMENT RATE IS RISING

In 2014, Medicaid's improper payment rate rose to 6.7 and totaled \$29.3 B. Fee-for-service programs accounted for \$15.9 B and eligibility issues accounted for another \$13.6 B. In 2015, Medicaid's improper payment rate spiked to nearly 10% and does not account for eligibility errors that may have arisen due to changes made by the Affordable Care Act.

Federal Improper Payments (billions)



Medicaid Improper Payment Rate

